

Skin Cancers in Hawaii (1993)

Norman Goldstein MD, FACP*

Basal cell cancers are the most common of all cancers. They rarely metastasize and very rarely kill. Melanomas, however, do kill! An estimated 20 people in Hawaii will die this year from malignant melanoma. Early diagnosis and treatment can save much morbidity—surgery, scars and other defects—and can save lives. This manuscript reviews melanoma data from several agencies in Hawaii and from the experience of the author's private practice. In his private practice, he has seen the incidence of melanomas jump from an average of one a year in 1970 to 1975 to 7.4 each year between 1986 and 1990. While basal cell cancers and melanomas occur more in Caucasians, they are seen in all races. Everyone can get skin cancer and melanoma. Physicians must teach their patients to Practice Safe Sun—Hawaii.

Basal cell cancers, the most common type of all skin cancers, are not reportable to any state or national recording agency. The American Cancer Society projects more than 700,000 new cases of basal and squamous cell cancers in 1993¹.

Stone and Elpern, Hawaii dermatologists, and their associates did a very thorough study of non-melanomas on the island of Kauai between January 1, 1983 and December 31, 1983². In their review of 131 Kauai residents with non-melanoma skin cancers, 89 had basal cell cancers and 24 had squamous cell carcinomas (5 had melanomas). The ethnic distribution was as might be expected.

Table 1:		
Ethnic Group	Basal Cell Cancer	Squamous Cell Cancer
Caucasion	80	19
Japanese	7	4
Filipino	1	1
Part Hawaiian	1	0
Totals	89	24

* Clinical Professor, Medicine (Dermatology)
John A Burns School of Medicine
University of Hawaii

Send reprint requests to:
Norman Goldstein MD FACP
1128 Smith Street, Honolulu, HI 96817

The authors also clearly showed the incidence of non-melanoma skin cancers on Kauai to be significantly higher than anywhere on the Mainland. The age-adjusted incidence for basal and squamous cell carcinoma was over twice that of New Orleans, 2.5 times that of New Mexico, and 5 times that of Seattle.

Dermatologists, plastic surgeons and pathologists agree that basal cell cancer is the most common of all cancers. Fortunately these rarely metastasize but do invade locally if untreated; hence, the old name "rodent ulcer." Deaths from basal cell cancers are very, very rare.

Melanomas, on the other hand, do kill. The American Cancer Society estimates 6,800 deaths from melanoma (4,200 male and 2,600 female) in 1993. They also estimate a total of 32,000 (17,000 male and 15,000 female) new melanomas will be diagnosed in the United States this year. Hawaii will have 70 of them, with 20 deaths!

Despite the fact that the number of melanoma deaths in Hawaii is relatively low compared to 425 lung cancer, 200 colon and rectal cancer, 100 breast cancer and 100 prostate cancer deaths, many of these melanoma deaths could be prevented with early diagnosis and treatment. This article will review the melanoma data from several sources in Hawaii:

- Queen's Medical Center (QMC)—Oncology Data Registry
- Cancer Research Center of Hawaii (CRCH)—Epidemiology Program
- Hawaii Medical Association — Hawaii Tumor Registry (HMA-HTR)

Between 1960 and 1961, The QMC Oncology Registry recorded 224 melanoma cases (141 male and 83 female). By far the largest ethnic group was Caucasian, 182 (81.3%); Hawaiian, Filipino and Japanese (11,10 and 9% respectively); Chinese 3 and others 9. The highest age groups with diagnosed melanoma were at 50 to 59 years (52 patients) and 60 to 69 years (55 patients). It should be noted that 4 patients out of the total were 19 years of age or younger, and 14 were aged 20 to 29 years.

The latest data available at this time at QMC indicate 4 more melanomas in the first 6 months of 1992 (2 Caucasian, 1 Hawaiian/part-Hawaiian, and 1 other). There were 3 females and 1 male. In summary, 142 male and 86 female patients were registered between 1960 and mid-1992 at The Queen's Medical Center Registry.

CRCH

LeMarchand and his associates in the Epidemiology Program of the Cancer Research Center of Hawaii have the largest data base of melanoma patients in the State. As part of

their dietary studies relating to cancer, they have examined 500 melanoma patients between January 1986 and June 1992. There were 306 males and 194 females in their study:

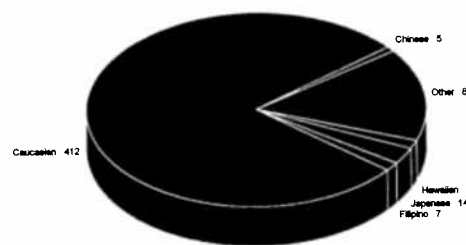
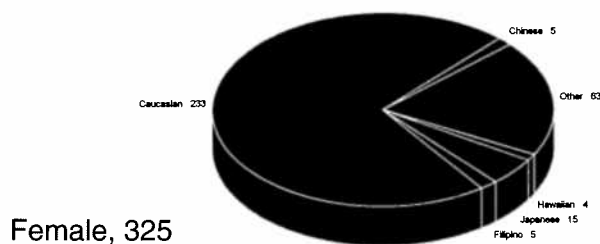
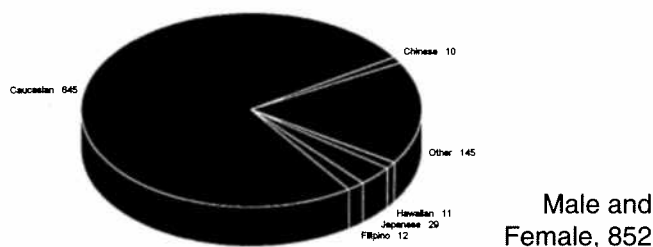
Table 2		
Ethnic Group	Male	Female
Caucasian	279	174
Hawaiian/Part Hawaiian	12	7
Japanese	8	6
Chinese	3	5
Filipino	1	2
Unknown	2	0
Other	1	0
Totals	306	194

HMA-Hawaii Tumor Registry

HMA-HTR is supported by the American Cancer Society, Hawaii Pacific Division, the Cancer Research Center at the University of Hawaii John A Burns School of Medicine and by the State Department of Health. HMA-HTR recorded 852 melanomas diagnosed between 1985 and 1991. In this 7-year period there were 527 males and 325 females. As anticipated, the majority were Caucasians (645) with 412 males and 233 females; the data clearly indicates other racial groups do get melanomas in Hawaii.

Regrettably there were 137 unknown races, but most can be assumed to be Caucasian. The complete data from the HTR include 15 different types of histologic codes for the 852 melanomas. This will be reported elsewhere.

Melanoma in Hawaii 1985 to 1991



Male, 325

Two rare but very significant types of melanomas deserve special mention here: there were 6 amelanotic melanomas (5 Caucasian and 1 Hawaiian). These are melanomas without the melanoma color, ie had normal skin color.

There were also 4 acral lentiginous melanomas: 3 in Filipino men and 1 in a Hawaiian. These usually are seen on the sides of the sole of the foot in members of the dark-skinned races.

The worldwide increase of cutaneous malignant melanoma is rising faster than any other cancer³. But as Koh et al⁴ have noted, most registries record data from patients admitted to hospitals and/or from biopsies interpreted in hospital-based laboratories.

This study clearly shows that Hawaiians and part-Hawaiians are developing melanomas.

Melanoma data from a private dermatology practice

In preparation for the "Practice Safe Sun—Hawaii" campaign for the American Cancer Society Hawaii Pacific Division, we were asked to review our melanoma cases.

During the years 1972 to 1993, we practiced Dermatology in downtown Honolulu; we have always seen a wide diversity of ages, ethnic groups and occupations. We were seeing more patients with melanoma over the years but the actual data really astounded us.

Table 3:		
Ethnic Group	Male	Female
1969	2	2.0
1970-1975	5	1.0
1976-1980	19	3.8
1981-1985	20	4.0
1986-1990	37	7.4
1991-1992	11	5.1

Some of these melanoma cases were diagnosed and treated by either oncological or plastic surgeons in Hawaii or on the Mainland and were referred to us for follow-up. About 80% were diagnosed in our office.

There were 56 male and 38 female patients; of the 94 patients examined, 87 still are living, 5 males and 2 females have died. As expected, the racial rainbow of skins included a vast majority of Caucasians (86); 4 of Japanese ancestry, 2 Chinese, one Latin-American and one Hawaiian.

(continued)➤

YOCON®

YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubiaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it, however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



AVAILABLE AT PHARMACIES NATIONWIDE

**PALISADES
PHARMACEUTICALS, INC.**

219 County Road
Tenafl, New Jersey 07670
(201) 569-8502
1-800-237-9083

SKIN CANCERS IN HAWAII (1993)

(Continued from page 127)

What Do These Statistics Mean?

According to the Skin Cancer Foundation, the death rate from malignant melanoma has more than doubled since 1950⁵. Given the current life expectancy of persons and the increasing rates of malignant melanoma, it is estimated that 1 out of 200 Caucasians living in the U.S. in the year 2000 will have a melanoma.

However, as we have seen by the above data, melanomas are not the private domain of the Caucasian. All races are susceptible to melanomas, basal cell cancers and squamous cell carcinoma.

With early diagnosis and proper treatment, the diagnosis of melanoma need not be a death warrant. Hawaii physicians must be aware of the clinical characteristics of melanoma, basal cell and squamous cell cancers. They must help their patients become a part of the health team. Patients must be given brochures to teach them to look for the early signs of melanomas and skin cancers.

Brochures with excellent color photographs are readily available from the American Cancer Society, The Skin Cancer Foundation, The Skin Phototrauma Foundation and from members of the Hawaii Dermatological Society.

Patients must be taught that the regular daily use of sun protectives with an SPF of 15 or higher not only will reduce the aging effects of the sun in Hawaii, such as wrinkles and actinic keratoses, but will reduce the chances of getting skin cancer and melanoma. Children who are taught to brush their teeth on a regular basis should also be taught to put on sunscreen every morning.

Avoidance of noontime outdoor activities is a must for residents and visitors alike. There are dozens of activities that can be enjoyed indoors during the peak ultraviolet-ray exposure hours of 10 AM to 3 PM. Protective hats and lightweight garments now are readily available if patients must be out in the open at "high noon."

We should not scare our residents and tourists away from the beaches and the great outdoor activities in Hawaii, but we must educate them to enjoy these activities—in moderation and with common sense.

We must "Practice Safe Sun—Hawaii."

ACKNOWLEDGEMENTS

Beth Myers, Cancer Research Center of Hawaii
Ruth Merz and Michael Green, Hawaii Health Registries
Ethel Masui, Queen's Oncology Data Registry
Lois Chinen, Stacy Olson, Gin Davila, Lana Lazaro, Anna English, Alice Greer, Eve Dagdag, Miyo Deal, Merle Stetser, and Russ Sowers.

REFERENCES

1. CA Cancer. *J Clin Cancer Statistics*. Atlanta, Ga. 1993: American Cancer Society. 1991;43:7-26.
2. Stone J L et al. Incidence of non-melanoma skin cancer in Kauai. *HMJ*. Dec 1983;45:281-286.
3. Glass A, Hoover R. The emerging epidemic of melanoma and squamous cell skin cancer. *JAMA*. 1989;(262 or) 286: 2097-2100.
4. Koh, H K, Clapp, R W, Lew, R A. Implication of under-reporting of cutaneous malignant melanoma in Massachusetts. *The Melanoma Letter*. Skin Cancer Foundation, 1991;Vol. 9,1: 3-4.
5. Day C L, Rigel, D S. *Melanoma Letter*. The Skin Cancer Foundation.1991;J. No. 1, 1.